island health

REQUEST FOR
PROXY REMOVAL FROM A MYHEALTH ACCOUNT

PART 1 – Requestor Information *(your own information)*			
Last Name	First Name		
Mailing Address	City	Province	Postal Code
Phone Number	Email Address (used for your MyHealth account invitation)		

PART 2 – Patient Information *(patient whose MyHealth account proxy removal is requested for)*			
Last Name	First Name	Middle Name(s)	
Former Name(s)	Date of Birth (YYYY-MMM-DD)	Personal Health Number (Care Card Number)	
Mailing Address	City	Province	Postal Code

PART 3 – Identify the reason Select **one** of the following reasons for proxy removal	
◯ I am the account owner and I am requesting a proxy be removed from my account	**Complete Parts 5 and 6 of this form**
◯ I have proxy access to a patient's account and I am requesting my proxy be removed	**Complete Part 6 of this form**
◯ I am neither the account owner nor the patient and I am requesting a proxy be removed from a patient's MyHealth account	**Complete Parts 4, 5 and 6 of this form**

PART 4 – Proxy/Patient Relationship Information Select **one** situation from below that best describes the relationship between the proxy and the patient.	
◯ The patient is 12 years old or older who is able to consent themselves	**Complete Request Purpose below**
◯ The patient is under the age of 12 years	**Complete Request Purpose below**
◯ The patient is an incapable person 12 years old or older who is not able to exercise their own health information rights	**Complete Request Purpose below**

Request Purpose ***Describe the purpose of why you are requesting proxy removal from a child or incapable adult's MyHealth account:***

PART 5 – Proxy Information *(individual whose proxy is to be removed from the patient, as identified in Part 2)*			
Last Name	First Name		
Mailing Address	City	Province	Postal Code
Phone Number	Email Address (used for MyHealth proxy removal)		

PART 6 – Requestor Attestation		
I attest that all the information I have provided is truthful and accurate.		
Requestor Name (print)	Requestor Signature	Date Signed (YYYY-MMM-DD)

Send your completed form to Island Health:

- Email: MyHealth@viha.ca
- In person at any Island Health Hospital Main Admitting Desk (route to VGH Health Records Department)
- Mail: Health Records Department, Victoria General Hospital, 1 Hospital Way, Victoria BC, V9Z 6R5

For more information on MyHealth visit www.islandhealth.ca/myhealth

The information provided in this form is collected under Section 26(c) of the Freedom of Information & Protection of Privacy Act.